A. Type of Handbook

Part P, Division II, is the service-specific portion of the Wisconsin Medicaid provider handbook. Part P, Division II, includes information about provider eligibility criteria, recipient eligibility criteria, covered services, payment rates, prior authorization, and billing instructions. Use Part P, Division II, with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Wisconsin Medicaid Managed Care Guide's provider section for general policy and regulation information for AFDC/Healthy Start recipients and the managed care program.

B. Provider Information

Provider Eligibility and Certification

General information on Medicaid certification requirements is in Section II of Part A, the all-provider handbook.

Certification Requirements for Physical Therapists (PTs)

For Medicaid certification:

- ✓ PTs must be licensed under ss. 448.05 and 448.07, Wis. Stats., and Med 7, Wis. Admin. Code.
- ✓ PTs who are granted border-status are exempt from the Wisconsin licensure requirement but must be licensed by the appropriate agency in the state in which they practice.
- ✓ PTs with temporary licenses or registrations are eligible for temporary certification. This certification is canceled effective 60 days after the next oral examination is given unless the provider submits proof of a permanent license to Wisconsin Medicaid before that date.

All PTs (other than PTs providing services *exclusively* for a rehabilitation agency, home health agency, school-based services [SBS] provider, or *at a licensed hospital location*) must be individually certified.

Certification Requirements for Physical Therapy Assistants (PTAs)

For Medicaid certification, PTAs must meet and do all of the following:

- ✓ Graduate from a two-year college-level program approved by the American Physical Therapy Association.
- ✓ Provide services under the direct, immediate, onsite supervision of a Medicaid-certified PT.
- ✓ Submit a copy of the PTA transcript.
- ✓ Submit the "Wisconsin Medicaid Declaration of Supervision for Non-Billing Providers."

All PTAs (other than PTAs providing services *exclusively* for a rehabilitation agency, home health agency, SBS provider, or *at a licensed hospital location*) must be individually certified. PTAs cannot be independent providers due to Medicaid supervision requirements. The provider number issued to a PTA is used *only* as the performing provider number on all submitted claims and may *not* be used as a billing provider number.

Note: Claims for services (other than rehabilitation agency, SBS, or *at* a hospital) must be billed with a group billing number or the certified PTA supervisor's provider number. The PTA's non-billing performing provider number must be included as the performer.

B. Provider Information (continued)

Change in Supervision, Employment, or Address for Certified PTAs
When a certified PTA has a change in his/her PT supervisor, the PTA must complete a new "Wisconsin Medicaid Declaration of Supervision for Non-Billing Providers" form. Refer to Appendix 15 of this handbook (or Appendix 34 of Part A, the all-provider handbook) for the supervision form. When a certified PTA also has a change in address or employment, the PTA must complete the "Wisconsin Medicaid Provider Change of Address or Status" form. Refer to Appendix 34 of Part A, the all-provider handbook, for the change of address and status forms. Please photocopy these forms as needed.

Therapists Certified by the Department of Public Instruction (DPI)
Therapists certified by the DPI who do not meet Medicaid's certification requirements are not eligible for individual Medicaid certification. Their services are billable only by SBS providers.

Physical Therapy Aides
Physical therapy aides are not separately certified by Wisconsin Medicaid. Refer to Section II of this handbook for information on physical therapy aide services and limitations.

Certification Requirements for Rehabilitation Agencies
Rehabilitation agencies must meet the criteria in HSS 105.34, Wis. Admin. Code: "For Medicaid certification, a rehabilitation agency providing outpatient physical therapy, or speech and language pathology, or occupational therapy will be certified to participate in *Medicare* as an outpatient rehabilitation agency under 42 CFR 405.1702 to 405.1726."

A rehabilitation agency does all of the following:

- ✓ Provides an integrated multi-disciplinary program of services to upgrade the physical functioning of handicapped, disabled individuals.
- ✓ Brings together a team of specialized rehabilitation personnel to provide these services.
- ✓ Provides services which, at a minimum, consist of physical therapy, speech pathology, rehabilitation program, social, or vocational adjustment services.

Rehabilitation agencies must meet a number of requirements which do not apply to independent therapists. The following is a general description of *Medicare* certification requirements for rehabilitation agencies which providers must meet before receiving Medicaid certification:

- ✓ Have a governing body and a full-time administrator.
- ✓ Have written personnel policies and written recipient care policies.
- ✓ Have a physician available to furnish emergency medical care.
- ✓ Provide social or vocational adjustment services to all recipients in need of such services by making available psychologists, social workers, or vocational specialists (either as salaried employees or on contract).
- ✓ Have certain safety features, such as a fire extinguisher, readily negotiable stairways, and lighting and fire alarm systems (a minimum of two people must be on duty at all times).
- ✓ Meet federal requirements concerning lighting, ventilation, lavatories, and general space regardless of whether these are required by state or local licensure laws.

B. Provider Information (continued)

- ✓ Have an infection-control committee.
- ✓ Have a full-time employee responsible for house-keeping services or must contract for such services.
- ✓ Have a pest-control program.
- ✓ Provide staff training and drills on disaster preparedness.
- ✓ Provide for quarterly review and evaluation of a sample of clinical records by appropriate health professionals.
- ✓ Conduct an annual statistical evaluation of its services.

PTs employed by, or under contract to, rehabilitation agencies are not required to be individually certified by Wisconsin Medicaid (unless they have private patients for whom they bill independently). However, PTs and PTAs employed by, or under contract to, rehabilitation agencies must meet all of the requirements for Medicaid certification. The rehabilitation agency must maintain records showing that they meet these requirements.

Medicaid Certification Process for Rehabilitation Agencies

Providers must apply simultaneously to Medicare and Wisconsin Medicaid for certification as a rehabilitation agency to ensure the effective certification dates coincide. Wisconsin Medicaid must verify the Medicare certification number before a Medicaid provider number is issued. Medicaid therapy group providers considering conversion to the Medicaid rehabilitation agency provider type may contact the fiscal agent. Contact the fiscal agent to obtain the application, obtain more information about the detailed conversion process, and to ensure services are billed appropriately during the conversion process. Refer to Appendix 2 of Part A, the all-provider handbook, for the fiscal agent's Provider Maintenance mailing address and Correspondence Unit telephone numbers.

Before receiving Medicare certification, a rehabilitation agency is surveyed by the Wisconsin Department of Health and Family Services (DHFS) under a contract with the federal Health Care Financing Administration (HCFA). The survey reviews the agency's administration and rehabilitation programs.

Certification for Durable Medical Equipment (DME)

Certified PTs and rehabilitation agencies do not need separate certification as a DME provider to provide the equipment identified in the DME Index as billable by physical therapy providers, or by those therapy groups, clinics, and rehabilitation agencies which include physical therapy. Separate DME certification is required to provide DME that are not identified as billable by these therapy provider types.

All DME policy and billing instructions for certified therapy and DME providers are in the DME and Disposable Medical Supplies (DMS) provider handbook, Part N. All therapy providers receive a copy of Part N. If you want additional copies, request the Part N provider handbook by writing to:

EDS
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

B. Provider Information (continued)

Types of Medicaid Provider Numbers Issued to Individuals and Organizations Providing PT Services

Individual Performing Provider, Billing

The following applies for a PT who can practice independently:

- ✓ The PT can independently provide services, bill Wisconsin Medicaid directly, and request prior authorization (PA) for the PT's services provided to Medicaid recipients.
- ✓ The PT can bill and request PA for the services of assistants the PT supervises.
- ✓ The PT's Medicaid provider number may be used as a billing number or a performing number.

The individual PTs included are the following:

- ✓ PTs in independent practice.
- ✓ PTs working under contract/arrangements with a nursing home where the PT acts as an individual performing provider (the nursing home's provider number must be used to bill Wisconsin Medicaid and request PA if the claims are to be paid to the nursing home).
- ✓ PTs working for an organization that is required to indicate the performer's number on the claim (the PT's number is used as the performing provider number if a group billing number is used [see next section]).

Individual Performing Provider, Non-Billing

The following applies for an PTA working under the immediate onsite supervision of a Medicaid-certified PT:

- ✓ The PT allows the PTA to provide services to Medicaid recipients. Those services are then billed to Wisconsin Medicaid using the provider number of the PTA's supervisor or clinic along with the PTA's number as the performing provider number.
- ✓ The PTA's Medicaid provider number can be used as a performing number, *not* as a billing number.

The individual PTAs included are the following:

- ✓ PTAs supervised by a Medicaid-certified PT in independent practice.
- ✓ PTAs supervised by a Medicaid-certified PT in an organization required to include the performing provider's number on the claim.

Group Billing Number, Performing Provider Number Is Required

A group billing number is issued as an accounting or billing convenience for groups of individually certified providers. The group billing number allows the group of individuals to do all of the following:

- ✓ Bill Wisconsin Medicaid.
- ✓ Receive one payment for each claims processing cycle.
- ✓ Request PA under the group billing number.

B. Provider Information (continued)

Examples of groups with individually certified providers include the following:

- ✓ *Therapy groups* - Provide two or more types of therapy (e.g., PT and OT or PT, OT, and Speech).
- ✓ *Therapy clinics* - Provide one type of therapy only (e.g., PT or OT).
- ✓ *Nursing home* - PT provided by PT staff employed by, or under contract with, the nursing home; the nursing home's provider number is used as the billing number.
- ✓ *Licensed hospital's off-site services* - Hospital PT staff providing PT services off the licensed hospital site (services cannot be billed as hospital outpatient; they must be billed fee-for-service and include the performing provider number).

Group Billing Number, Performing Provider Number Is Not Required

The following applies for some organizations employing PT staff who meet the Medicaid individual certification requirements (exclude school-based services [SBS] provider's staff) and does not require a performing provider number:

- ✓ The organization may bill Wisconsin Medicaid, receive one payment for each claims processing cycle, and request PA under one provider number.
- ✓ No separate Medicaid certification is required for individual performing providers. However, the Medicaid-certified organization must maintain records documenting that their PTs and PTAs meet Medicaid certification requirements for PTs and PTAs (excludes SBS providers).

Examples of organizations employing PT staff who are not required to obtain a separate Medicaid performing provider number include the following:

- ✓ Rehabilitation agencies.
- ✓ Licensed hospitals (only for services provided at the licensed hospital site; individual certification of staff is required for services provided off the licensed hospital site and claims require the performer's provider number).
- ✓ Home health agencies with PTs providing therapy services.
- ✓ School districts and Cooperative Educational Service Agencies (CESAs) certified as SBS providers; therapy services provided at school must be billed with an SBS provider number. SBS staff must meet DPI certification and licensure requirements, not Medicaid certification requirements.

Scope of Service

The policies in Part P, Division II, govern services provided within the scope of the profession's practice as defined in Section 448.01 (4), Wis. Stats, N 12, Wis. Admin. Code, and HSS 107.16, Wis. Admin. Code. Refer to Section II of this handbook for covered services and related limitations.

Payment Methods

Physical therapy and rehabilitation agency services are paid the lesser of the following:

- ✓ The provider's usual and customary charge.
- ✓ The maximum allowable fee.

B. Provider Information (continued)

The Medicaid maximum allowable fee applies to one treatment unit, which coincides with the specific Current Procedural Terminology (CPT) and HCFA Common Procedure Coding System (HCPCS) procedure code descriptions. (Refer to Section IV of this handbook for information about Medicaid procedure codes.) Payment for treatment less than the procedure code unit per session is prorated. Additional units are paid only when a full unit of service is actually provided. Refer to Appendix 4 of this handbook for specific procedure codes and treatment units.

Facility Overhead Costs

Payment for direct and associated overhead costs is included in the payment for each treatment unit.

Provider Responsibilities

Specific responsibilities as a certified provider are stated in Section IV of Part A, the all-provider handbook. Refer to Section IV of Part A, the all-provider handbook, for information about the following:

- ✓ Fair treatment of the recipient.
- ✓ Maintenance of records.
- ✓ Recipient requests for noncovered services.
- ✓ Services rendered to a recipient during periods of retroactive eligibility.
- ✓ Grounds for provider sanctions.
- ✓ Additional state and federal requirements.

C. Recipient Information

Verifying Recipient Eligibility

Eligible recipients receive identification cards monthly that are valid through the end of the month issued. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and, when applicable, an indicator of health insurance, HMO, and Medicare coverage.

Note: Check the recipient's identification card *before* providing service to determine recipient eligibility and any limitations to their coverage.

Section V of Part A, the all-provider handbook, provides detailed information about Medicaid eligibility, identification cards, temporary cards, restricted cards, and eligibility verification. *Review* Section V of Part A, the all-provider handbook, *before* rendering services. A sample identification card is in Appendix 7 of Part A, the all-provider handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining physical therapy services. Refer to Appendix 4 of this handbook for procedure codes and their applicable copayment amounts.

Copayment exemptions include the following:

- ✓ Emergency services.
- ✓ Services provided to nursing home residents.
- ✓ Services provided to recipients under 18 years of age.
- ✓ Services provided to a pregnant woman if the services are pregnancy-related.

C. Recipient Information (continued)

- ✓ Services covered by Medicaid-contracted managed care programs to enrollees of the managed care program.
- ✓ Family planning services and related supplies.

Providers must make a reasonable attempt to collect copayment from the recipient. Providers are not allowed, at their discretion, to waive the recipient copayment requirement. The provider cannot deny a service to a recipient who fails to make a copayment.

The fiscal agent automatically deducts applicable copayment amounts from payments allowed by Wisconsin Medicaid. Do not reduce the billed amount of the claim by the amount of recipient copayment.

No copayment is deducted after the first 30 hours or $1,500 of services per calendar year.

Recipients Enrolled in Managed Care Programs

Recipients enrolled in Medicaid-contracted managed care programs (including Medicaid Health Maintenance Organization, or HMOs) receive a yellow identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. Refer to Chapter 4 in the Wisconsin Medicaid Managed Care Guide's provider section for the HMO Medicaid ID codes.

Providers must check the recipient's current identification card for managed care program coverage before providing services. Wisconsin Medicaid denies claims submitted to the fiscal agent for services covered by Medicaid-contracted managed care programs. Physical therapy claims must be submitted to the managed care program.

For recipients enrolled in a Medicaid-contracted managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization for physical therapy services.

Managed care programs exclude physical, occupational, and speech therapy provided in the school from coverage under their program. Refer to Appendix 22 of Part A, the all-provider handbook, for more information.

Refer to Wisconsin Medicaid Managed Care Guide's provider section for additional information about managed care program noncovered services, emergency, services, and hospitalizations.

D. HealthCheck

HealthCheck is Medicaid's federally mandated program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). HealthCheck consists of a comprehensive screening of eligible recipients under the age of 21, which includes the following:

- ✓ Review of growth and development.
- ✓ Identification of potential physical or developmental problems.
- ✓ Preventive health education.
- ✓ Referral assistance to appropriate providers of service.

HealthCheck also includes targeted outreach and case management services to "at risk" children to ensure that these children have access to needed medical, social, and educational services.

D. HealthCheck (continued)

Note: Wisconsin Medicaid covers medically necessary physical therapy services under the physical therapy benefit. HealthCheck benefit services also must be medically necessary. A request for prior authorization of physical therapy services that is denied for lack of medical necessity under the physical therapy benefit generally is not approved under the HealthCheck benefit because both benefits use medical necessity as the same prior authorization criteria and requirement.

Wisconsin Medicaid considers requests for medically necessary physical therapy services (under the HealthCheck benefit) which are not specifically listed as covered services when all of the following conditions are met:

- ✓ The service requested is for an individual under 21 years of age.
- ✓ The service is medically necessary to correct or improve a condition or defect discovered during a HealthCheck/EPSDT screening.
- ✓ The service is one which is an allowable service under federal regulations.

All such services require prior authorization for payment. Refer to Section III of this handbook for prior authorization information.

Refer to Section IV of Part A, the all-provider handbook, for additional information on HealthCheck "Other Services."

E. School-Based Services (SBS) Benefit

Background

Provisions of 1995 Wisconsin Act 27, the biennial budget, established a School-Based Services (SBS) benefit. The benefit allows schools and cooperative educational services agencies (CESAs) to bill Wisconsin Medicaid for medically necessary services provided to Medicaid-eligible children under age 21 or for any school term during which the individual became 21 years old. This benefit became effective for dates of service on and after July 1, 1995.

Covered SBS Services

The following services are covered under the SBS benefit when they are identified in the child's Individualized Education Program (IEP) or Individualized Family Service Program (IFSP) and certain requirements are met:

1. Physical therapy.
2. Occupational therapy.
3. Speech, language, audiology, and hearing.
4. Nursing.
5. Psychological services, counseling, and social work.
6. Developmental testing and assessments when they result in an IEP/IFSP;
7. Transportation.
8. Durable medical equipment (DME) not covered under Medicaid's DME benefit.

E. School-Based Services Benefit (continued)

Certification for School-Based Services: Impact on Therapy Providers

Effective July 1, 1996, all services covered under the SBS benefit that are delivered at a school site must be billed under the school district's or CESA's SBS provider number. This includes services delivered by school and non-school employees (or CESA and non-CESA employees) who are under contract or arrangement with the school district or CESA to deliver services at the school site.

Services under the SBS benefit that are delivered at a school site may not be billed by individuals or groups with the following Medicaid certification that duplicates SBS certification:

- ✓ Physical therapy and therapy assistants.
- ✓ Rehabilitation agency.
- ✓ Therapy groups.
- ✓ Occupational therapy and therapy assistants.
- ✓ Speech and hearing clinics.
- ✓ Audiologists.
- ✓ Speech pathology/therapy.
- ✓ Transportation.
- ✓ Nurse practitioners.

Effective July 1, 1996, individual providers cannot be certified for the above duplicate service areas when a school, school district, or CESA is the provider's payee. School districts and CESAs are not eligible for new group certification for the above provider groups on and after July 1, 1996.